RURAL ACCESS TO ELDERLY PROGRAMS

HEARING

BEFORE THE

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UNITED STATES SENATE

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RURAL ACCESS TO ELDERLY PROGRAMS

MONDAY, AUGUST 3, 1981

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Sioux Falls, S. Dak.

The committee met, pursuant to notice, at 9 a.m., in the Bergeland Center, Sioux Falls, S. Dak., Hon. Larry Pressler, presiding.

Present: Senator Pressler.

Also present: Debra Swenson, legislative assistant to Senator Pressler; and Ann Langley, professional staff member, Special Committee on Aging.

OPENING STATEMENT BY SENATOR LARRY PRESSLER, PRESIDING

Senator PRESSLER. As always, it is a great pleasure to be able to hold a field hearing in South Dakota. I would like to thank the Bergeland Senior Center for making this nice facility available to us. The cooperation of the director of the center and his staff are greatly appreciated.

Growing old is inevitable. Our Nation's demographic profile is changing to the point that by the year 2000, 31.8 million Americans will be over age 65. I believe our Nation has a responsibility to make the lives of these elderly individuals as comfortable and as secure as possible. While there are numerous Federal programs for the elderly, I have continually found that such programs are not always as accessible in our rural areas.

Therefore, the purpose of this hearing is to examine some of these programs in terms of accessibility. The first panel today will focus on home health care—a program that I have strongly supported. I believe programs should be available so that the elderly could remain in their own homes if they so desired.

The second panel will allow us to examine volunteer and employment programs. As a cosponsor of the Older Americans Act, I believe these programs have been extremely effective in fostering a sense of fulfillment in later life, and I look forward to hearing how these programs can be made more available to the rural elderly.

Finally, I believe we need to look at social security. In the last few months, social security has been the focus of much attention. There has been a great deal of confusion in terms of the President's proposals as well as the solvency of the system. I want to assure you that Congress and President Reagan do not intend to break faith with the millions of Americans who receive social security benefits. Nor do we intend to renege on promises to employees who expect to retire in the near future.

Changes may be necessary to maintain the long-term solvency of the system. However, Congress will not act irrationally on this matter. The Senate Aging Committee and the Senate Finance Committee have held a series of hearings to review all aspects of social security. In doing so, I believe we can maintain the fiscal integrity and redirect social security to its original purpose as a stable base around which working men and women can plan for retirement.

I wish to thank all the witnesses who have traveled from many parts of the State to be here today. The suggestions and information we receive will help us to formulate legislation responsive to the needs of the rural elderly.

I would like to welcome our first panel on home health care. The panel includes Lois Christensen of Beresford, Mary Ann Garris, health services coordinator, of Vermillion; Joyce Sugrue, director of nursing and home health care, of Pierre; Pat Eggers, executive director of the Visiting Nurse Association in Sioux Falls; Lois Schuller, Visiting Nurse Association, again of Sioux Falls; and Kathi Skoglund, with the Office of Adult Services and Aging, Sioux Falls.

Please proceed, Mrs. Christensen.

STATEMENT OF LOIS CHRISTENSEN, MEALS-ON-WHEELS COORDINATOR, BERESFORD, S. DAK.

Mrs. CHRISTENSEN. Well, I've been asked to talk about the meals-on-wheels program which we have in Beresford. We started our program in December of 1962, and we have been running continuously since then. We have had a total of at least 126 individual people receiving meals during that period of time. Some of them have been on our program for many months, sometimes for several years. We have had several couples, elderly and incapacitated couples. We have had some that have been on the program for as short as 1 day.

Our program is entirely sponsored locally. We do not have any government assistance at all. In the beginning, we solicited funds from various local organizations, church women, women's clubs, and so on. We had a very excellent response. So each year we make a plea from our local organizations, and we're still getting the excellent response. We do have to have the funds to provide the initial supplies too, the plates and the carriers, and so on.

In our program, the meals are prepared in the State home, which is about a mile out of town. Our volunteers are people from women's clubs, churches, extension clubs, auxiliaries, and in the wintertime our volunteer coordinator has a plan which he tries to get retired couples for the months of January and February, which are usually the bad months, but last year was not.

We pick up our meals at Bethesda at 11 o'clock. We must be there exactly at 11, because if we don't, we may not get our meals. The State says that's the only time. They serve the same meals as in the home. We do have special diets, diabetic, low fat, cholesterol, indicated diets, and so on. We don't go into any rigid special diets because the home is not able to provide those.

We have had very little trouble getting volunteers. Our volunteer coordinator sets up a program for the year. In January, we get a chart, I get a chart, and she has each organization assigned so many

weeks, and it is up to them. They each have a coordinator in their own local organizations, and it is up to them to provide the people to deliver the meals. Our volunteer coordinator, once she contacts the organization contact person, she's through with it, because it is up to them to see that someone is there to deliver the meals. We have had very few times when someone didn't show up. About 3 weeks ago, one of them forgot, and I was called about 11:20 and they said nobody was there to get the meals.

That basically is our program. We are very proud of our program, because we feel it's been very successful. It is totally limited to the city limits. We don't go out of the city limits. It is not limited to the elderly. We have had a few people incapacitated who were not elderly and have had a very satisfactory program as far as our local situation is concerned.

Senator PRESSLER. Next I call on Joyce Sugrue.

STATEMENT OF JOYCE C. SUGRUE, PIERRE, S. DAK., DIRECTOR OF NURSING AND HOME HEALTH CARE, SOUTH DAKOTA DEPARTMENT OF HEALTH

Ms. SUGRUE. Senator Pressler, ladies and gentlemen, I'm Joyce Sugrue, director of the community health nursing program in the South Dakota State Department of Health. Presenting testimony with me is Mary Ann Garris, community health nursing coordinator for the southeastern section of the State, and Kathi Skoglund, supervisor for adult services and aging in the Department of Social Services in Sioux Falls. My remarks will consist of a brief overview of home health services presently offered, as well as some of the problems and suggested solutions associated with the availability and funding of these services. Mary Ann will present the local viewpoint of home health service delivery, and Kathi will present the State and local viewpoint of the South Dakota State Department of Social Services.

The South Dakota community health nursing program provides a variety of professional nursing services such as health promotion and education, health maintenance, and direct care to the elderly in their place of residence. The latter two comprise the home health care program. The health maintenance program is for individuals who have chronic but stable medical problems, and require nursing support to remain stable. Last year, the State department of health home health agency provided home health care services to 3,609 individuals, primarily the elderly.

The purpose of the home health care program is to provide professional and supportive health services to persons in their home, to assist them in achieving or maintaining their optimal health status, to facilitate earlier discharge from hospitals, and to provide care and comfort to the terminally ill.

The home health care program is administered jointly by the State departments of health and social services. The responsibilities of each agency are established in formal contractual agreements between the two departments. This allows the State to maximize availability and funding, and to avoid duplication.

The geographic scope of the availability of these services is defined along State lines. Some services such as the health maintenance pro-

gram may be limited along county lines, based upon the contractual agreements with the counties. Direct patient care on an in-home basis is available statewide upon receipt of a referral and under a physician's direction.

Medicare certification is a key component in the State home health care program. Through the passage of recent legislation revising medicare reimbursement for home health services, progress is being made to eliminate certain administrative barriers to access of home health care for specific individuals. Following are some funding and administrative problems that inhibit the availability of home health care in South Dakota. Elimination of these problems would enhance availability.

First, it is difficult to secure funds to provide service to low-income elderly, who are not poor enough to qualify for medicaid and who require home health services not payable by medicare. These are considered private pay patients and are put on a sliding fee scale according to the income. Our experience shows approximately 90 percent of the private pay patients had an annual income below $6,864 for a person living alone or $9,057 for a two-person household, which is so low that they are zero percent pay. Medicaid eligible patients receive service to fill the gap between the Department of Social Services under the personal care program, but there is no funding source for nonmedicaid eligibles, and unless funds are in the program budget to cover the cost, home health care is not available to this group. Provision for the State to use Federal home care funds more flexibly would allow coverage for this group and therefore make the service more available to them.

Second, medicare reimbursement regulations and guidelines sometimes prevent the services from being delivered to patients. An example is the issue of whether medicare will or will not pay for the prefilling of insulin syringes for blind diabetics. Medicare will not pay for this as a skilled nursing service in States where it is legal for nonlicensed staff to prepare medication, and it is implied medicare will pay in States, such as South Dakota, where it is only legal for licensed staff to prepare medications.

However, in fact, the final outcome is not that way. Medicare views the prefilling of insulin syringes for blind diabetics as a nonprofessional service even though State law does not. Therefore, it is impossible for us to receive payment for this service alone. There should be flexibility to allow for differences in State laws.

Another example is that the burden of paperwork required by medicare dictates the nurse spend as much time in the office as with the patient. This decreases the number of patients that can receive the service. Written documentation, either by the physician and/or the nurse, justifying that the service is needed, must be attached to each bill to medicare. This same procedure is not required of all other types of medicare providers. Our record of accurate and justified claims is very credible. We should be recognized for this by allowing us to submit bills without the added documentation. We then would be able to provide more service to patients.

Another problem in the category of reimbursement is that the rate charged for skilled nursing services is based on a per visit charge rather than on a specific service provided or the length of time spent. This is

confusing to the consumer, as the charge is the same for one-half hour or 3 hours and does not allow for any incremental charge for the private pay clients. The medicare regulation should be revised to allow for a charge based on time or service so that the private pay patient could afford to avail themselves of home health services.

Third, the final problem area relates to the nursing shortage in the rural nature of the State and the effects upon availability of home health care. In some of the very rural parts of South Dakota, it is difficult to hire nurses because all of the nurses who wish to work are already working. It is virtually impossible to convince a nurse to locate in these areas unless he or she has a personal reason to do so. Home health care may not be available at all to residents in some areas, because nurses can't be hired to fill positions. The number of patients is very low in those areas and may be very far apart. A nurse may be able to visit one or two patients a day because of the time spent in travel.

The nursing shortage that has been widely publicized has not yet affected our program severely; however, the potential is there for us to be affected. The demand for nurses nationwide is higher than it has ever been, and enrollment in schools of nursing has dropped. Federal funding for educational programs for nurses should continue so there is a continued supply.

I thank you for the opportunity to share with you, and Mary Ann will present the local viewpoint for nursing. Please let us know if you wish additional data or other information and we will be happy to supply it.

Senator PRESSLER. Thank you very much. I'll next call on Mary Ann Garris.

STATEMENT OF MARY ANN GARRIS, HEALTH SERVICES COORDINATOR, VERMILLION, S. DAK.

Ms. GARRIS. Senator Pressler, ladies and gentlemen, the community health nursing office sets the scene for the actual provision of home health care services to the citizens of the local community. At this time I would like to give you a brief synopsis of the process of the provision of these services.

The community health nurse may receive a referral or a request for services from many of the following: From a health care institution such as a hospital or nursing home, from a physician, family, client, friend, or interested persons. This referral may be written or we may receive a phone call or have personal contact.

The community health nurse then would contact the proposed client and set up a time for a home visit. On the home visit, the nurse will evaluate the patient's needs by making a data base assessment of the problems, using client and family input, nurses' skilled observations, and information received from the referral. The nurse will determine the level of care needed, determine the number of visits necessary, and the need for other services. She will discuss this with the client and decide which services will be provided and under which program. For instance, the home health agency, medicare program, personal care, or our health maintenance program.

In the office, then, the nurse will prepare a care plan, contact a physician for orders as necessary, and send a care plan to the physician as indicated by the program. The nurse would then arrange for other services that are needed, such as a home health aide; for which we would make a request to social services. If the patient needed meals-on-wheels, we would contact the local meals-on-wheels agency. If the client should need homemaker services, but not personal care services, we would again request this from social services. Mutual care plans would be developed with social services as necessary, and as indicated by the level of care.

The nurse then would prepare a care record in which all services, care plans, reports, progress notes, and so forth, are kept on the patient. On successive home visits, the nurse would provide the nursing care and see that the related services were provided according to the patient's needs, the doctor's orders, and the nursing care plan. The nurse will report regularly to the medical provider as necessary, at least every 60 days for the medicare clients, and at least every 3 weeks if she's serving the client daily. Services will be continued for the patient until the goals are reached and client is able to function without continued services.

In Senator Pressler's request for input, he indicated the following question, "How can home health care services be more widely utilized?" Mrs. Sugrue has already referred to some problems of utilization of services in our State, and I would like to address the following:

One agency in my area has seen the home health care caseload increase when the nurses were able to make weekly visits to their local hospital to review the patient's post-discharge needs. This opened communications and assisted each agency in understanding community services. The ability for this to happen, however, is hampered due to the lack of staff time and no funding mechanism for marketing purposes.

The necessity of thorough documentation and other activities required by regulatory functions for the home care agency to assure certification do reduce actual service time to the patient. This also affects the utilization of direct client service and increases program costs. Positively, I believe our utilization of services has increased at the local level by the contractual arrangement between the Department of Social Services and Department of Health. This arrangement has increased coordination of communication between both departments and increased the home care caseload in our area.

Finally, I expect that there is no home health care provider in South Dakota that is not interested in providing their specific health care service at the lowest possible cost to the client. Perhaps the greatest need for proper utilization of all health care services is open communication, cooperation, and reduction of turf barriers, so that the client can move within a total health care system and receive the necessary service where it can be given at the most reasonable cost at the time of need.

Kathi Skoglund will now be presenting the department of social service's activities related to the health program.

Thank you.

Senator PRESSLER. Kathi, we welcome you.

STATEMENT OF KATHI SKOGLUND, SUPERVISOR, ADULT SERVICES AND AGING SOCIAL SERVICES, SIOUX FALLS, S. DAK.

Ms. SKOGLUND. Senator Pressler, ladies and gentlemen, I'm Kathi Skoglund, adult services and aging social services supervisor for the the Sioux Falls area. Carole Boos, program administrator for adult services on aging is unable to attend this morning, and my statement will encompass not only the statewide overview, but also the local picture of home health service delivery.

The office of adult services and aging purchases for or provides to older people in South Dakota a number of services, such as congregate and home delivered meals, transportation, senior center programs, and homemaker/home health aide services programs. From July 1, 1980, to June 30, 1981, the aides served approximately 5,700 older people in their own homes. This program is funded by three titles of the Social Security Act, titles XVIII, XIX, and XX; and title III(b) of the Older Americans Act. As Mrs. Sugrue mentioned, the home health program is administered jointly by the State departments of health and social services, and both departments are striving together to meet the program requirements of a home health agency.

As we look to the future, the reduction in title XX funding and the cap on title XIX threaten the current service level of the in-home program. This reduction is occurring when the program has waiting lists and nursing home care costs are escalating. The problems mentioned by Joyce in her testimony will be magnified with the expected reduction in funds.

I will now share with you the local system as it currently exists. Homemaker/home health aides take part in 40 hours of training and observed participation before being certified by the departments of health and social services to provide home health services to clients. These aides provide services funded by any of the title programs I mentioned earlier. This utilization of aides provides maximum efficiency to the home health program by eliminating duplication of services. The aides report 100 percent of the time they spend in client care, travel and charting, separating services provided in each program. Aides working in all four title programs, not only avoids duplication, but also it is less confusing to the elderly and/or handicapped person to relate primarily to one care giver.

Title XVIII home health services are requested by community health nurses and the homemaker/home health aide supervisors respond by assigning an aide within 72 hours. Title XIX personal care services are requested by physicians, nurses, other sources, family or the medicaid eligible person themselves. Our department of social service social worker and department of health community health nurse review doctor's orders, assess the need, and write the mutual care plan. The plan lists all tasks for every individual involved, and the client, nurse, social worker and aide sign it.

The nurse and social worker request that an aide be assigned and the community health nurse is present during that aide's initial visit. She also visits the client monthly and reevaluates the situation with the social worker every 90 days.

Titles XX and III(b) funded homemaker services are requested and a social worker assesses the client's needs. Because of the high number of requests for this service, eligible persons with medical

need for services are then placed on waiting lists in many areas of the State because of the limited number of homemaker hours available under titles XX and III(b). Those who are eligible for title XVIII medicare and title XIX medicaid services receive services without waiting. As social workers from my office, we average ongoing caseloads of approximately 90 to 100 clients.

The homemaker/home health aide program is one of our largest programs, but we have other programs such as protective services. We investigate adult abuse. We protect the rights of those in nursing homes. We assist with placements in nursing homes and adult foster care, and we assist with information and referral, advocacy, as well as other generalized services.

Thank you.

Senator PRESSLER. Thank you very much. I next call on Pat Eggers, executive director of the Visiting Nurse Association.

STATEMENT OF PATRICIA L. EGGERS, EXECUTIVE DIRECTOR, VISITING NURSE ASSOCIATION, SIOUX FALLS, S. DAK.

Ms. EGGERS. Thank you. Minnehaha County is a little different than the other counties in the State. I won't repeat any of the things because I think Mrs. Sugrue and the rest of them have explained what the goal of home health care is.

Minnehaha County has not been a recipient or participant, I should say, in the home health program of the State department of health. Therefore, in 1965, some concerned citizens conducted a study to determine the needs in the county, and as a result of that, the Visiting Nurse Association was established.

We're a nonprofit private organization, rather than being part of the State. As I mentioned, we were established in 1965. We're governed by a board of directors with 18 citizens from Minnehaha County representing the members of the board. We do the same work basically as is performed by the State community health nurses in providing home health care, skilled nursing, physical therapy, and home health aide care.

In 1975, we established a contract with McKennan Hospital for a discharge planning program. One of our nurses spends part of her day in the hospital visiting the patients that will be going home so that we have a smooth transition when that patient leaves the hospital. Everything is arranged for them prior to discharge from the hospital.

We're funded by the United Way and by Minnehaha County and also receive fees for service. We also have a sliding scale system. It is estimated now that we collect about 30 percent of the fees on those people in the sliding scale. I think the other girls mentioned pretty much the problems we're having with medicare, medicaid, and the limitations of provisions under those programs.

We have been able to maintain our cost on a much lower basis. We've done a study around the area. We're about $10 lower per visit in Minnehaha County than is customary throughout the rest of the area.

We work in close cooperation with the personal care program with social services, and also with the senior companion program, which we have found very beneficial and helpful to our clients. Lois Schuller will mention more about our local needs here.

Senator PRESSLER. I next call on Lois Schuller, Visiting Nurse Association of Sioux Falls.

STATEMENT OF LOIS E. SCHULLER, SUPERVISING NURSE, VISITING NURSE ASSOCIATION, SIOUX FALLS, S. DAK.

Ms. SCHULLER. Senator Pressler, ladies and gentlemen, I'm very happy to be with you. The Visiting Nurse Association is a nonprofit agency that serves just Minnehaha County. We serve clients regardless of age, creed, or ability to pay. We have been functioning since 1967, which is about 14 years now. We've had some of our clients for 14 years. We've also had some clients for only one or two visits. Last year we served 529 clients. There were about 7,820 visits. This year we've made about 700 visits per month and plan to be making about 8,000 visits this year.

We get medicare and medicaid reimbursement for some of these patients on those services, sometimes third-party payers, such as Blue Cross/Blue Shield. Some of our patients are eligible for VA benefits, and they pay for the home health care, and then because we are a United Way agency, we can have a sliding scale fee. Our fees are $10 for an aide, $20 for an R.N., and $25 for a registered physical therapist. We do need physician's orders to make these home visits.

You may be wondering why people over 65 who are eligible for medicare have to pay. That's because medicare classifies skilled nursing sometimes differently than the physicians or the nurse. They have their definitions of what is a skilled nursing visit. Joyce Sugrue already referred to that when she was talking about the filling of insulin syringes. That's the type of problems we have many times.

Some of the benefits of home health care is that a patient can be discharged from the hospital sooner than he would otherwise be. He can sometimes prevent or delay institutionalization or nursing home placement. The nurse can offer supportive services, such as instructing the patient and the family with treatments, medications, and diet. This care is usually at a lesser cost than what it would be if they would have to be institutionalized.

We assist in community services by offering family guidance and work in maternal child visits, and growth and development. We have a school nursing program where our nurses go out into the community, make school nursing visits and stay at the school for 1 day a week. We have a craft mobile which does not need physician's orders, and they bring crafts to the people in their home and provides companionship for them. I have some brochures available if anyone would like that. That's all I have.

Thank you.

Senator PRESSLER. Thank you very much. I think the panel did an excellent job. I believe we heard from everybody on the panel.

First of all, as you know, South Dakota was awarded a systems development grant to plan and manage long-term care services. After a series of forums throughout the State, a recently released report indicates that home health care services are not utilized at the level they could be, because of limited public awareness of home health services, limited physician utilization of home health nurses, and a lack of referrals from hospital discharge sources.

How do you think we can address these problems in an effort to maximize utilization? What types of educational and informational programs could be initiated to improve awareness?

Ms. SUGRUE. I can respond to that from the State department of health. The contract that he referenced was done through the State department of health, and those things were found. I think the question refers back to the same thing that Mary Ann was referencing in her presentation. There are some areas of the State where we feel there is limited awareness of the elderly and other younger people who are disabled about the home health care program. Also, physicians may be limited in their knowledge of the availability of the program, and hospital discharge planners, who generally are nurses in most of the hospitals in South Dakota, may not be aware that home health is available. The way that we try to take care of this is to have the local community health nurse—there are 50 of those around the county—50 counties with community health nurses, talk with the physicians, meet with senior citizens groups, go to the senior centers, nutrition sites, visit with hospital nurses, and tell them about the program. We have done very little as far as a real public awareness campaign. We've developed some slide tape shows between the department of social services and department of health. We use those in formal presentations.

I think one of the things that hampers us is that we have not put anyone on as a public relations or public information person for the home health care program. One of the reasons for that is the lack of funding. Also, I think those in health care programs are reticent to advertise their wares sometimes, so we do it sort of low keyed in the local communities. We don't do a big large public relations campaign. Does that answer the question?

Senator PRESSLER. What are the State restrictions on reimbursements for home health or personal care services under medicaid?

Ms. GARRIS. Senator Pressler, I think I can answer that. The medicaid program, as far as those people who are on title XIX for home health care, we use the same regulations that we would for medicare when we are determining what visits, and so on, can be given. For the personal care program, the client is most often restricted to the home. We must have physician's orders for the services.

Senator PRESSLER. There must be a physician's order for the services?

Ms. GARRIS. Yes.

Senator PRESSLER. Under the President's proposals for medicaid, States would be given the flexibility to design their medical assistance programs to meet the needs of the elderly populations for acute care and long-term care. Do you feel that such flexibility will enhance the access of quality health care to our elderly?

Ms. SUGRUE. I think it's to our advantage in South Dakota to have the most flexibility that is allowed. We do work very well together between the State departments and the private agencies in the State. We are really very small compared to some of the more urban largely or highly populated States. We can work together well. We use all of the different title funding sources, as Kathi referred to, have our staff funded out of many, many different sources. Large urban areas are unable to do this. If we're given more flexibility, we can do that better.

Senator PRESSLER. Thank you. The recent report that I mentioned also included an assessment of long-term care on South Dakota

Indian reservations. Do any of you have a knowledge of how the home health care services are working on our Indian reservations, and do you have any suggestions in that area?

Ms. SUGRUE. I don't want to speak for Indian health service or tribal governments, or anything like that, but recently State department of health community health nursing and Indian community health nursing have been working together to try to provide home health care to Indian clients on the reservations. We are just beginning to do this. It is not a service that's provided by Indian health service per se. They do a lot of in-home care, but they don't receive outside funds for it like they do in hospitals and in some of the other areas. We've been trying to work with them. Our first area that we think we're going to get going is Pine Ridge. We have Indian clients on our caseload throughout the State, but generally not on the reservation.

Senator PRESSLER. Here is a question someone has submitted. This question is, how much increase in referrals on caseloads are the agencies in both Sioux Falls, Vermillion, and in the very rural areas of the State able to handle? In other words, are there services and funds for services available which are not being used? My impression has been that people have not been able to obtain these services to the full extent of need. Do agencies serve all applicants? If not, what are the reasons people cannot receive service?

Ms. EGGERS. There is a waiting list for title XX—Social Security Act—and title III–B—Older Americans Act—funded homemaker services. There is no waiting list for title XIX—Social Security Act—medicaid-funded personal care, provided through the South Dakota Department of Health and Social Services.

Senator PRESSLER. Mary Ann, go ahead.

Ms. GARRIS. In the community health nursing program in my area, I don't know of anyone who has been turned down for skilled nursing services. We provide the number of employees that we feel will fill the need, and if I need, for instance, more nursing hours in one county than another with the flexibility that we have with our home health care program, I can change those hours to another area, if necessary. So I am sure we have not intentionally turned down anyone.

Senator PRESSLER. From the meetings I have held in South Dakota it's been my impression that senior citizens, given the option, will stay in their own homes or take care of themselves as much as possible, and that some statistics indicate that up to 20 to 25 percent of the people in nursing homes could care for themselves if some kind of congregate housing or visiting nurses were available.

Does the panel have estimations of how many of their patients or acquaintances or people in their program would require institutional care if it weren't for some of the programs that exist?

Ms. EGGERS. Senator, I have to answer off the top of my head. We do send a report to the county each month designating how many people would be institutionalized, in our opinion, were we not seeing them. I am guessing, but I think it's around 30 percent. As Lois mentioned, we have several people that we have had for 14 years on our caseload, and I know they would have been institutionalized had we not been going in several times a week to provide them with the necessary help.

Ms. SKOGLUND. In one of the studies that was done, it was shown that approximately 50 percent of those people who are receiving homemaker services at this time would be in need of more care in another type of institution had homemaker services not been available. Currently, in our area, on our four-county area of Minnehaha, Lincoln, Turner, and McCook, we have 83 people on the waiting list, and we have some people who have called saying that without this service, they will not be able to maintain their own homes. They will need to leave their homes.

Senator PRESSLER. With that, I thank our panel for coming. I know all of you and I know how hard you work. I think in this area I'm always amazed when I visit people in our nursing homes in South Dakota or anywhere in the health services area. We're lucky in the State to have the quality of people that we have and this panel is an example of the dedication and care our health service personnel provide.

[Subsequent to the hearing, Senator Pressler submitted questions in writing to the members of the panel. Those questions and responses follow:]

TO LOIS CHRISTENSEN

Question. What provisions are made for the meals-on-wheels program in the rural areas surrounding Beresford? If the program is not provided, what suggestions do you have for reaching these rural areas?

Response. At present, no provisions are made for a rural meals-on-wheels program, as we are limited to the city limits. I know of no plans for such a program.

TO MARY ANN GARRIS AND JOYCE C. SUGRUE

Question 1. Case management and assessment are primarily funded in South Dakota through title XX. Are these services available to medicare and private pay clients?

Response. One of the conditions of participation for medicare certification is that the registered nurse must make evaluation visits and coordinate services for the patient. Evaluation visits and coordination of services are just synonyms for assessment and case management; and these are an integral part of home health care services provided to medicare and private pay clients, but not defined as a separate service. Medicare generally does not reimburse for these services, even if required in regulations, unless a technical skilled nursing service is provided at the same time. Nursing evaluation and case coordination require equal or higher skill than many technical services and should be recognized as a reimbursable service.

Question 2. In your testimony, you mentioned an example of the need to revise medicare regulations to allow more flexibility in home health. Could you please expand on needed regulation revisions and provide additional examples?

Response. I brought out four points at the hearing where I thought a change in medicare regulations would be beneficial. I will make clarifying statements on each point:

(1) Personal care services—In order to receive reimbursement from medicare for home health services, the major service required by a patient must be a professional service. Not infrequently, it is not the need for professional services as much as assistance with activities of daily living, such as bathing, walking, eating, and some health-related housekeeping activities, that prevent the elderly from remaining in their own homes. Medicaid has an optional program which meets these needs with physician's orders and supervision by a registered nurse, however, there is no such program for medicare only patients.

(2) The interpretation of Federal regulations expressed in manual guidelines sometimes is confusing or questionable. I used the example of payment for prefilling of insulin syringes for blind diabetics. Medicare will not pay for a registered nurse prefilling insulin syringes even if South Dakota law precludes home health aides from so doing, unless the registered nurse also provides another service

medicare will define as a skilled service. In other words, Federal regulation does not preclude payment but the interpretation does.

(3) Justification for the service with each medicare claim—Each home health medicare claim that is submitted to the fiscal intermediary must have a report attached showing an update on the patient's condition and justifying the need for continued service. Other medical providers such as physicians and hospitals are not required to submit justification with their claims. Only if the intermediary questions the service is justification required. The amount of paperwork required for home health care is extensive and could be lessened by the use of random audits.

(4) Reimbursed by medicare per nursing visit rather than by the hour of service.—The reimbursement rate for each nursing visit is based on cost to the agency. The average length of a home health care skilled nursing visit in our agency is one and a half hours, however, the reimbursement rate is the same no matter the actual length of the visit. If reimbursement could be based on actual time spent, say in half hour increments, this would be beneficial to private pay patients as the charge would be less for shorter visits. Currently, the private pay patients must pay on the same schedule as medicare reimburses us.

To Patricia L. Eggers

Question. Could you please provide a breakdown of how many of your clients are supported by medicare, medicaid, or other sources? How many home health days do your medicare clients generally use?

Response. The following information is based on our 1980 statistics: medicare patients, 215; medicaid patients, 18; selfpay patients, 296. Total, 529.

The medicare patients have an average of 14 visits. The selfpay patients have an average of 16 visits.

To Lois Schuller

Question. You mentioned the problems with medicare's definition of what constitutes a skilled nursing visit. Could you please expand upon what these specific problems are?

Response. The largest problem we have regarding medicare is that clients think when their physician orders home health care, medicare will pay. In some areas of the county, this may be true; but our intermediary, Blue Cross, Blue Shield of Sioux City, Iowa, certainly wouldn't allow blanket coverage. We get medicare coverage only when the physician orders a skilled nursing service for a specific treatment, i.e., injection, dressing change, catheter care. The service is covered for a specific length of time. The nurse has to document every 30 days the patients condition and the need for the service. Medicare's definition of a skilled nursing service is very limited.

There has been confusion regarding blind diabetics. These patients have been taught to give their own insulin, but can't see to fill the syringes. A registered nurse can only prefill syringes for 1 week at a time or the insulin deteriorates in the syringe. It is against South Dakota State law for an aide to prefill insulin syringes, but medicare will only pay for an aide to prefill syringes. The blind diabetic needs weekly nursing visits to assess his diabetic status and skin condition. A blind diabetic cannot see to test his urine for sugar, cannot see if his feet are developing sores, and has decreased sensation in his lower extremities. A small sore can quickly become infected for a diabetic because of the poor circulation.

Another area of confusion is with the home health aide service. This is payable when there is documentation that a skilled nursing service, i.e., registered nurse or physical therapist, is also needed in a 60-day period. This means if the physician orders a vitamin B–12 injection one time a month to be given by the registered nurse, the patient can also receive a bath by a home health aide. If a registered nurse needs to see a patient post surgery, i.e., to check wound healing and assess patients condition, a home health aide can be used to assist the patient with a bath. However, if a patient doesn't need a registered nurse, but needs help with bathing, they can't be covered. There are many elderly people who because of arthritis, strokes, and heart problems are unable to bathe themselves, but they cannot get medicare coverage.

Clients who receive physical therapy in the hospital, assume that when they come home medicare will continue to cover the service. We have been rejected many times with these cases. We get coverage on post surgicals, i.e., total hips, total knees, and fractures; but when patients have a stroke, crippling arthritis, multiple sclerosis, we can't get coverage. These patients with chronic illness have

to struggle just to maintain. Maintenance is not covered, yet if these people aren't continually exercised they regress and need more care. It may not seem important to keep working with someone so they can transfer without assistance. But if they can transfer without assistance, they can be independent in more activities of daily living. If they can transfer without assistance, they can get into a wheelchair and to the bathroom. If they can't transfer, someone always has to be with the patient.

The confusion comes when medicare pays for Mrs. Smith and not for Mrs. Jones. Clients can't understand where the differences come between skilled and nonskilled visits.

Senator PRESSLER. The second panel is on the employment volunteer programs. Jo Ann Eisenbeisz, director, retired senior volunteer program, Aberdeen; Al Kuehn, retired senior volunteer program, Sioux Falls; Anna Zierke, senior companion program, Sioux Falls; Leona Meyer, green thumb program, Huron; Martha Watson, foster grandparent program, Aberdeen; and Joyce Wood, executive director of the foster grandparent program, Aberdeen.

STATEMENT OF JO ANN EISENBEISZ, DIRECTOR, RETIRED SENIOR VOLUNTEER PROGRAM, ABERDEEN, S. DAK.

Ms. EISENBEISZ. Senator Pressler, ladies and gentlemen, the retired senior volunteer program is an ACTION program that helps keep people age 60 years of age and over contributing members to the community. It prevents mental and physical stagnation, a stagnation which too often leads to senility. Doing volunteer work, a ride provided to the place of service, working together with other volunteers, even receiving a light meal at the worksite, all provide moral and physical support. RSVP helps senior citizens continue a useful, purposeful life, thereby avoiding costly nursing home care.

RSVP volunteers may serve in any nonprofit organization or public agency. The volunteers may serve as long as they do not displace a paid employee. Volunteer assignments can range from assisting in libraries and museums, clerical or reception work, aides in schools, helping with crafts or reception work, helping or performing in choruses and kitchen bands, driving people to doctors, visiting shut-ins, working with youth, delivering meals-on-wheels, administering gift shops in hospitals, serving at nutrition sites. I might say in Aberdeen, we have four nutrition sites, and they are all manned by RSVP volunteers. We also are doing something very new in Aberdeen. We are taping legal law cases for visually handicapped lawyers in South Dakota. We are assisting in energy, conservation, and assisting in any community support centers. Sharing is what RSVP is all about, trying to make life a little bit better for someone else and themselves.

In South Dakota, we are very fortunate to have nine RSVP projects. We have a project in Aberdeen, Canton, Huron, Mitchell, Rapid City, Sioux Falls, Spearfish, Sturgis, and Webster, In 1980, throughout the State of South Dakota, we had 2,013 volunteers who served and share their talents and time in their communities. In 1980, they contributed 372,873 hours of volunteer services in their community. If you took that times the minimum wage, that would be a contribution back into their community of $1,155,906.30.

In Aberdeen, we have 35 stations that have 300 volunteers serving in it. We receive our local support for space from the city of Aberdeen,

our maintenance and operation for the van comes from the Brown County Commission, maintenance and volunteer transportation, supplies, and meals come from the State, and insurance, supplies, and postage from the United Way.

Thank you.

Senator PRESSLER. Thank you very much. I'll next call on Al Kuehn.

STATEMENT OF AL KUEHN, RETIRED SENIOR VOLUNTEER PROGRAM, SIOUX FALLS, S. DAK.

Mr. KUEHN. Senator, ladies and gentlemen, your question to me in the letter was what experiences do I participate in with the RSVP program? I think as a matter of fact, I should mention one thing. How many people that have come in the building today noticed the sign in our entrance? I think this is a credo that RSVP should bear in mind. "It is not how old you grow, but how you grow old." If you remember that, you should get involved and not sit in the rocking chair and deteriorate.

In my experience, we service 36 areas in Minnehaha County and the surrounding counties. What I do, I present a background on the Presidents of the United States. As a has-been, I pursued it, I open it up with the people when I do this, and I got a great response. It makes you recall things that happened in the past. I also put on musical programs which is quite prevalent. It's called "Name That Tune." With a very good piano player and myself, we put on a program.

In the senior citizens center, I've been involved in every program; meals-on-wheels, the nutrition program, and I even help the janitor. So I do all that work, because I want to get involved. If you will do that, you will not be bored. I can say that very truly.

One thing that was also asked me in the letter was how to improve the center? I think we can improve the service clubs in our program, because they are all interested in us as citizens of the United States, and I think the service clubs involved in RSVP would be a great asset.

Thank you very much.

Senator PRESSLER. We thank you. Anna Zierke.

STATEMENT OF ANNA ZIERKE, SENIOR COMPANION PROGRAM, SIOUX FALLS, S. DAK.

Ms. ZIERKE. Thank you Senator Pressler. My name is Anna Zierke, most people call me Ann Z. I live at Western Heights Apartments here in Sioux Falls and have been a senior companion for 2 years. I came from Rapid City, S. Dak., about 3 years ago. I have been a widow for 9 years.

I speak for all the other 45 companions when I say how much the program means to all of us, and to the clients who are all special people to us. The senior companion program serves more than 150 clients monthly. As for myself, when I first came to Sioux Falls, I was a very lonely person, and the companion program gave me a release from my own problems.

We are given a 40-hour orientation which is planned by our very efficient Connie Pettinger and her staff. At these meetings we learn how to give CPR, plan balanced and nutritious meals for people who have diabetes, cancer, and had strokes, and so forth. We have nurses that

tell us how to assist these people. Our senior companions are able to stay in their own homes longer.

We have efficient bus service to take us to and from our assignments. It does not provide transportation for the folks we serve, though, because of the shortage of funds. Project Call A Ride must rely on 30 volunteer drivers per week.

We do a lot of different activities besides providing companionship. We read to some, play games, teach some crafts, take them for walks, help them with their exercises, and do some errands. Some who have eye problems, we help them with bookwork, do minor chores, read to them, write their letters. We help them with grooming and personal care then assist with their meal planning. We also have a fun time when the companions all get together for a Christmas party, have a pot luck or picnic in the park.

This program has meant a lot to me, and I do really mean it. I do hope it can be continued and offered in other areas outside of Sioux Falls.

I thank you.

Senator PRESSLER. Thank you very much. Next we will hear from Leona Meyer, the green thumb program in Huron.

STATEMENT OF LEONA MEYER, GREEN THUMB PROGRAM, HURON, S. DAK.

Ms. MEYER. I have not been on this job as area leader too long, but I will try and do my best. The senior community service employment program, the SCSP program, was established to foster and promote part-time jobs in the community, service activities for jobless, low-income persons who are at least 55 and have poor employment prospects.

Green thumb is an arm of the National Farmers Union. Thanks to them for their efforts. The green thumb program requests they take a physical examination when entering the program and also meet eligibility guidelines. We try and keep hours the same all through the year. They offer 24 hours a week, paid holidays, sick leave, and vacation time. Also capable of performing tasks involved in job assignments. Some of the placements are men and women working at the State fairground, county, city parks, and college assignments, office jobs in job service and college and teachers aides.

How many of the elderly have all this education? Green thumb employs 333 green thumb workers in the State. We are at a standstill, as employers are not hiring the elderly because they have many other applicants to choose from, college graduates, and other experienced people in many fields.

The elderly have a lot to worry about. You take the social security program, rise in electric rates, gas rates, including telephone rates, water, sewer, and taxes. At one time, they have planned they had enough money to carry them through life, but what about hospital and doctor fees and nursing homes?

Transportation is a big item. A lot of people that I visited on many trips around five counties need glasses, dentures, some have diabetes, need attention, or cataracts of the eyes. They can't afford to see doctors, less have operations. I am an area leader of five counties. I

have 24 people working under me and I see the need, but what am I to do about helping each one?

I have diabetes myself. I have problems making my social security and green thumb income reach. When I started 2 years ago, the insulin was $5.95 a bottle, which lasts 3 weeks. Now, it costs $9.95 for 3 weeks. The needles I use last 3 months, they cost $16.50. I'm supposed to see a doctor for blood tests and urine tests once a month, but I can't afford that either. They cost $30 a trip. Right now, I need my glasses changed, but will have to wait as I'm paying on a hospital bill. I do have Blue Cross/Blue Shield insurance, but they don't cover everything.

Last winter, being a very mild winter, a lot of people could not get on the fuel program for various reasons, but what about the programs offered this winter? How is it going to be handled?

We hope you will consider the elderly. My husband is 80 years of age, but still he is sawing and splitting wood for our winter's heat. There is no help from the fuel program, because we burn wood.

Transportation, a lot of the elderly depend on some of the transportation to get them where they want to go, such as job service, unemployment service, doctors, and so forth. Some travel 50, 60 miles to our office to get these services. Some of the people out in the western area have discontinued their telephone service.

Green thumb has a role in trying to do away with the negative stereotypes about the older worker. Our motto is "ability is ageless."

Thank you.

Senator PRESSLER. I think your remarks are good because Senators and staff reading these remarks, get a feel for what's happening out away from Washington, and we thank you. Martha Watson of the foster grandparent program in Aberdeen.

STATEMENT OF MARTHA WATSON, FOSTER GRANDPARENT PROGRAM, ABERDEEN, S. DAK.

Ms. WATSON. Senator Pressler, ladies and gentlemen, I'm a foster grandparent, and I work in the arts and crafts at the boys and girls club in Aberdeen. It is just one of the many places in Aberdeen where foster grandparents minister to the boys and girls. I love my work. It gives me a chance to do what being a foster grandparent means. Foster means to cherish, to nourish, to help to develop and promote. One of the meanings of parent is source, and so the program does this for us. It gives us a chance to give our love to the boys and girls and in return they give us so much, a feeling of being needed, the love of the children, seeing their progress, and in my case they gave an old maid a chance to be a grandparent.

The foster grandparent program does so much I do not have time to tell you all of it. Many students who have learning disabilities are back in the mainstream because of a loving grandparent. The court in Aberdeen refers to the boys club as first offenders. I'm happy to say that 80 percent of them do not become second offenders. This is a wonderful thing. I've heard the director of the boys club say many, many times, much of this is due to the care and concern of the grandparents that work there.

My job is to teach arts and crafts. I also do what most of us don't find time to do, and that is listen. I listen to all their hurts, their concerns, all about the tests they have, about their pets, about their family things, and the feeling a lot of them have about being unwanted and alone. I'm happy to say that I can say to them that I care. Another part of the foster grandparent program is that we as foster grandparents get together. We have a good time and we love and care for one another. There's only one thing wrong with the program. There's not enough of them. In this day when so much emphasis is placed on money, it is a real investment. If boys and girls can be helped to become good taxpaying citizens instead of liabilities, and senior citizens can find a useful place to feel wanted and needed and put to use their abundance of love and time, everyone should be in favor of this program.

The success of the program in Aberdeen is due to the hard work and dedication of Joyce Wood, the director, and Joycel Goodrich, the administrative assistant, and they didn't pay me to say that. I'm proud to be a foster grandparent, and my wish for every senior citizen is the opportunity to be one.

Senator PRESSLER. I'll next call on Joyce who's been mentioned here. She's the executive director of the foster grandparent program in Aberdeen. I believe we only have the foster grandparent program in Aberdeen and on the reservation in South Dakota; is that right? We appreciate you being here. It would be great to expand this to other parts of South Dakota.

STATEMENT OF JOYCE WOOD, EXECUTIVE DIRECTOR, FOSTER GRANDPARENT PROGRAM, ABERDEEN, S. DAK.

Ms. WOOD. Correct. Senator Pressler and friends of the aging problems in South Dakota, first of all, I bring you greetings from 70 older Americans in Aberdeen who remember well your efforts to get there in 1978 to greet them. They have very warm feelings for you and watch you every step of the way.

Our program is, as you've heard from one of my foster grandparents, a program which at present is reaching a radius of 40 miles around Aberdeen. Seventy older Americans who are serving a three-county area, and I have several grandparents who drive their personal cars as far as 54 miles a day in order to be a foster grandparent. We have a wide spectrum of service in our program. We deal with the learning ability of children, disability children, retarded, we deal with the physically handicapped and, I might say, our retarded and physically handicapped children are in State institutions.

A new part of our program is working with youthful offenders, which has been traumatic and very dynamic as far as making an impact upon hardcore delinquents. We've also worked with emotionally disturbed, abused, and neglected.

An area of our program which is proving beyond what I ever dreamed it would be has been working with homebound children, children who have been placed in the home and no longer can be worked in the school system because of their incapacity to get around, and our grandparents go into the home and work there 2 hours a day and then move on to another home for 2 hours a day, in order to

keep these children aware of the classroom activities. The schools have cooperated beautifully with our program, and consequently children are still feeling a part of society and experiencing the love and attention of a foster grandparent.

Another factor is the fact that grandparents are willing to push wheelchairs into the regular classroom, and this has encouraged the teacher to allow a physically handicapped child in the classroom, and it does not become a burden to the teacher who has many other children in that classroom.

I'd like to, for documentation purposes, read to you a letter that came from a foster parent. It's very short and tells what happened because a foster grandparent that was involved with an abused child and was diagnosed as tremendously emotionally disturbed at the time that social services took over. She wrote this letter to us saying:

> I just want to say a big thank you to you for supplying help for Barry when his need was so great. Grandma Lindberg was just what the doctor ordered and was a real blessing to Barry in bringing him out of his emotional problems. You might be interested to know that after he had been back in our home with Grandma Lindberg working with him 5 days a week for 3 months, the mental health people could find no emotional disturbance whatsoever. We credit this to the healing of his memories because of the loving and learning and doing provided by a loving foster grandparent. May God continue to bless your program.

I might also say, Senator Pressler. I could give you a volume of documentation on the positive effects that this program has had upon our society. Spectacular results, in fact, I might even name some of them as miracles. I might say we have had children who have never walked before learned to walk, children who never talked before learned to talk because of grandparents who have come there day after day and have put up with physical abuse, if I might add, in order to help quiet the hearts and minds of these children. We have children who have been institutionalized and today are deinstitutionalized because foster grandparents have been there at Redfield State Hospital since 1972.

I'd like to tell you a little bit about the foster grandparent that applies for this program. These are people who are tremendously work oriented, who do not want to settle for a rocking chair. They come in—I always ask in their application for a statement as to why they want to become involved in the program. Invariably they say they want to do something to help someone else. They love children. They are so willing to go to work at whatever cost it may be to them, physically and whatever. They want to avoid welfare. They want to avoid food stamps. I have to take an annual income review every day, every year, in my program, and I'm finding that the little bit of pittance that they had put aside for funeral expenses, et cetera, has diminished, and yet they are still fighting going on welfare and accepting SSI, food stamps. They still want to maintain their own homes and they, some of them, I have been able to convince to take low-income housing.

We have referrals from the mental health center for foster grandparents. People who have been having mental depression because they've been taken out of their surrounding, farm surroundings, and put into an apartment in the city, The families come to me and say,

their mother is in depression, could you do something, could your program do something? We've seen people taken out of the alcoholic ward and have been referred to the program and have gotten off the bottle and have become very effective in the program. We're proud of the fact that these people, when they find that they are worth something, that they can't express their love, that they have an improved self-image. They are ready to go to work. It becomes a two-way street. The children love them and they are loved back.

If a blizzard comes in South Dakota in that northern area and it lasts for 3 days and you can't get on the road, especially to Redfield, I have calls, numerous, when can we get going? I'm climbing my walls here. I want to get back to work. I have grandparents who testified to the fact that they have to say that they think that they love their retarded children at Redfield State Hospital more than they do their own children. I don't know if that's really a good statement, but there's something that they really feel about these children that they didn't have that satisfaction in rearing their own children.

I would like to suggest to you, Senator Pressler, that something be considered in regard to the difference between rural transportation needs and urban transportation needs, an example is Salt Lake City, Utah. It costs the foster grandparents there 10 cents to travel to their site and back again, whereas there's no way that I could transport foster grandparents in Aberdeen, S. Dak., for 10 cents.

I also would like to have you consider, with OMB or whoever the powers that may be, that administrative costs are becoming prohibitive as far as starting new programs; but I do feel that especially in these rural areas, that we who are already in administration of programs could have satellite programs extending out. This year we expanded to Groton, S. Dak., which is 17 miles east of Aberdeen; and we've been able to do this with once a week supervision and tremendous cooperation from the Groton elementary system. We've also had a request from Bristol, S. Dak., to enter into their school system with foster grandparents. If this continues, requests continue to come, we're going to have to have coordinators or supervisors. What I'm really saying is that South Dakota could do like Minnesota. They have one State director and satellite programs branching out from there.

Another big issue is that when a young person reaches the age of 21, the foster grandparents are not able to work with them any longer, or at least not able to accept them into the program. You and I know that chronologically some of the children with special needs have not advanced that far mentally. It's a very painful experience to have the adjustment training center call and say "You work with this child at Redfield State Hospital, he's now living here in the Harmony Home and in the adjustment training center. Can you continue your work with that child?" We have to say no, because he has reached the age of 21. I do think this is one area that needs to be attacked.

I thank you for listening.

Senator PRESSLER. Thank you very much. Your comments were especially valuable because in these hearings we always try to put a dollar value on things. Although you couldn't state a specific dollar value, you pointed out that not only does the foster grandparent program provide some work for a limited number of senior citizens, but also it provides a benefit to handicapped children and others in a community.

Although it is difficult to place a dollar figure on this type of program, I would appreciate you giving us the dollar return to a community, or a very human return, whichever you want.

Ms. WOOD. Thank you for the opportunity to help me give you a little bit that I had prepared for you. I have some information here from a former speech that it's $47.60 an hour that the mental health center asks for counseling emotional disturbed people. I find that this is a figure that should be taken into consideration. Also, it's $8 an hour in Aberdeen for tutoring a child outside of the classroom We have grandparents. I have several grandparents with master's degrees doing remedial reading work and tutoring children. The grandparents, by the way are receiving $2 an hour. Also, just recently it was my privilege to plead the cause of a young lad who was to be sent to the training school after numerous offenses toward society. It costs approximately $5,600 a year to keep a person in the State training school, and because of joining together our hands for the cause of saving a youth, I believe that South Dakota has been saved $5,600 by the love of foster grandparents and the concern of other people in the community who are already being employed and should be working for developing youth to their highest potential.

Thank you.

Ms. EISENBEISZ. In my first presentation I was a little nervous, but now I've pulled my thoughts together and would like to add that RSVP volunteers receive no stipend for their volunteer services. In Aberdeen, I mentioned that in 1980, we had 79,000 volunteer hours, and if you take that times the minimun wage, the Aberdeen community would receive $264,747 for RSVP services. In the State of South Dakota, the nine RSVP projects have 2,013 volunteers who contributed 372,873 volunteer hours. At the 1980 minimum wage of $3.10 per hour, that service is worth $1,155,906.30 to the State. In Aberdeen, we receive $30,000 from the Federal Government, so in comparison to the $30,000 I feel that's quite a contribution back to the community.

Senator PRESSLER. Anybody else? Leona, anything on green thumb?

Ms. MEYER. This is not for green thumb. The senior center at Huron, S. Dak., where I have given 975 hours of volunteer work on hauling the mentally retarded to their place where they were educated and work on different projects and things, and they are doing a wonderful job.

Senator PRESSLER. I understand that Connie Pettinger of the senior companion program of Sioux Falls is here and has some statistics.

STATEMENT OF CONSTANCE L. PETTINGER, DIRECTOR, SENIOR COMPANION PROGRAM, SIOUX FALLS, S. DAK.

Ms. PETTINGER. Thank you. I'm director of the senior companion program. Roughly the senior companions receive, it's not a wage, it's a stipend of $2 an hour. They give 20 hours of service per week, and roughly I'm calculating we're giving about 40,000 hours of service in Sioux Falls per year. I did some quick checking with those around me a few minutes ago. Kathi Skoglund tells me homemaker service total costs are around $9.36 per hour. I think Pat Eggers gave a figure for skilled nursing service at around $20 an hour earlier. You might want

to check that. We're paying senior companions a stipend of $2 an hour. So, for roughly $3,500 to $3,800 a year, covering administrative expenses and direct volunteer expenses, we're able to offer that kind of service in our community.

Does that help?

Senator PRESSLER. Yes, and describe your program here a little bit in terms of its activities.

Ms. PETTINGER. I'd like to refer to what Ann Zierke gave as testimony. Ann is one of our very fine senior companions in Sioux Falls. We are the only senior companion program in the States of South Dakota or North Dakota at this time. There are five senior companion programs in region 8. We're very fortunate that the Good Samaritan Society wanted to sponsor this program in Sioux Falls. We brought it to Sioux Falls with the help of ACTION in fall of 1978. It's a model program in that all of our services are offered in the home, versus some of the other senior companion programs around the country which deal with nursing home service. ACTION asked us to study that aspect particularly, and to assign all of our volunteers to persons in their own homes. So, it relates directly to the needs of the volunteer and to the needs of the person to stay in his own home. We find we're serving many people over 75, many in their eighties and nineties and we've had good success with that in Sioux Falls. We would like to see the program expand into other areas, if possible; it's limited now.

I also picked up the statistics from the Good Samaritan staff that are here, that nursing home care is about $30 a day right now.

Senator PRESSLER. Al, do you have something to add?

Mr. KUEHN. Relatively speaking, in regard to RSVP, I think it's a good thing to mention that to qualify for this program, you have to be at least 60 years of age, and the one reason we are requiring and asking for more people, we have 102 people in our surrounding area servicing 36 sites, and we are looking forward to having more volunteers, because the more volunteers, the more talent we have to present to the people who are either incapacitated or are participating in the program.

Thank you very much.

Senator PRESSLER. Next, we will hear from Pat Tuley, codirector, retired senior volunteer program, Sioux Falls.

Please proceed Ms. Tuley.

STATEMENT OF PATRICIA TULEY, CODIRECTOR, RETIRED SENIOR VOLUNTEER PROGRAM, SIOUX FALLS, S. DAK.

Ms. TULEY. First, a personal comment. In today's mobile society syndrome, home is where employment transfers take the family. Wherever that has been, local seniors become the extended family. I have dealt with them socially and professionally for many years. I know the retired senior volunteer program has done wondrous things for these folks. I have seen elders depressed, frustrated, and lonely, come alive when learning they are needed and have something to share. They share their time freely—they are not paid—except for transportation reimbursement, if they drive their private auto-

mobiles. They have a lifetime of experience which they volunteer freely, along with their time.

Another plus of the retired senior volunteer program are the guidelines. There are no income or educational stipulations. The program is open to anyone aged 60 and over, willing to share.

The hardest part is parting with these folks when it does come time for them to live with families or go into nursing homes. I cannot help but believe their mental and physical well-being is kept stronger by being active through RSVP, therefore prolonging that step. More than 50 percent of our RSVP volunteers are 75 years of age.

During January through June 1981, volunteers served about 7,059 hours. If that number of hours were calculated at the prevailing minimum wage of $3.35, the communities have received $23,647.65 in service from retired seniors in 6 months. Whether they know it or not, probably the life of every citizen within the communities have been touched by an RSVP volunteer.

Senator PRESSLER. Each of our participants will receive one or two questions from staff on some of the technical aspects of how the programs are organized and applied for, and the paperwork involved, and so forth. We thank our panelists very much. This has been a useful assertion into our record. Thank you very much.

[Subsequent to the hearing, Senator Pressler submitted questions in writing to the members of the panel. Those questions and responses follow:]

TO JO ANN EISENBEISZ

Question. Does the Aberdeen program have outreach to the rural elderly? If not, how do you suggest possible expansion to these areas?

Response. The Aberdeen senior program does not have outreach in the rural area for the elderly. There is the possibility that RSVP volunteers, extension groups, 4–H clubs or service clubs could do outreach in the area. One volunteer said he would like to do this, but felt he should be reimbursed for meals and mileage.

Enclosed find additional comments from Elaine Arntz, area manager, Aberdeen senior nutrition.

COMMENTS OF ELAINE ARNTZ

I would suggest that the Social Security Administration include a simplified directory of services available in every social security and supplemental security income check sent out, at least quarterly.

Local governments, township boards, town councils, extension clubs, community clubs, and PTA's, should all be made aware of programs available to their senior citizens and local senior centers. Nutrition programs could then serve as focal points, explaining requirements, etc., to those who are eligible.

Transportation is vital to many rural elderly in order to apply for many programs. I feel the elderly would be better served by bringing them in on rural transportation. If they qualify for food stamps or energy assistance, they would still need transportation to use these things effectively.

The only exception I would make would be for the incapacitated and local homemakers. Medicare nurse programs should be aware and expected to provide referrals to these people.

TO LEONA MEYER

Question. How many of your clients move from subsidized to unsubsidized jobs? What are the difficulties you encounter in job development?

Response. As you know, part of Green Thumb, Inc.'s obligation toward the U.S. Department of Labor is to place 15 percent of enrollees into unsubsidized jobs each grant year. During the 1980–81 grant year, South Dakota Green Thumb placed into full- and part-time jobs 50 enrollees. Thus far, this contract year, South Dakota Green Thumb has terminated 14 enrollees into unsubsidized jobs achieving 28 percent of the goal.

The blockages to older workers remaining in or reentering the job market are many, but here are a few of the most important obstacles.

—Lack of jobs in rural areas. The depressed nature of the rural economy is a well-known problem, with available jobs usually going to younger workers with families. An oft heard comment is, "older people have social security to rely on and don't need to work."

—Age discrimination/mandatory retirement. Although mandatory retirement for Federal employees is now age 70, many employers maintain the age 65 standard for retirement. Although many studies show that older workers compare favorably in terms of productivity, absenteeism, accident rates, health and attitude; many employers still weigh age strongly in making a hiring decision.

—Self-concept of older workers. Most title V employees do not have the knowledge to make a job search. South Dakota Green Thumb is striving to provide training in job seeking skills to enrollees and also to build motivation and confidence in green thumb employees.

—Social security disincentive to work. The social security earning limitation penalty for those under 72 who take work is a consideration for many older workers.

Senator PRESSLER. Next we come to the social security discussion. I believe strongly that we must keep our social security commitment very firm. I have also gone on record very strongly for retaining the minimum benefit and look forward to the views of the panelists on this issue.

STATEMENT OF JOHN R. PETERSON, ASSISTANT DISTRICT MANAGER, SIOUX FALLS, S. DAK., DISTRICT OFFICE, SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. PETERSON. Senator Pressler and audience, I'm very glad to have the opportunity to speak with you today on some social security matters for a few minutes. I'm sure all of you realize that social security probably is in the eyes of the limelight, dealing with the elderly more than any of the other programs. The programs that have been discussed here today are very, very important, very needed. When you're talking about a program that affects elderly people, I can think of no program anywhere near the size and the impact of social security.

I was very pleased to see Senator Pressler very concerned. His interest in social security, for example, his commitment, looking into the minimum benefit, the understanding of the social security financial status, which is in the minds of almost every American, regardless of age, today. I appreciate his willingness to look at some of these issues.

One concern that I can see in dealing with social security is in the tremendous number of phone calls we receive across the State. That's what we're really here talking about, South Dakota, the tremendous concern over what is happening and, as I see it, the tremendous lack of understanding of social security in South Dakota. You know, we're seeing so many different proposals being raised in the Congress and the newspapers daily, and they are only smatterings. I'll give you an example of a couple things.

One of the issues I'm sure many of you heard of is the possible elimination of the minimum benefit. Everybody earmarks that $122. People look at their check and say, "I get $135.70, or I get $153.10, or $173.10; it's not going to affect me." Many of those people will be

affected by the minimum benefit, because the minimum benefit starts at $122, and after you've been on social security 1 year, you get a cost-of-living increase so it doesn't stay at $122. A tremendous number of people are saying that doesn't affect me, but it does. In December, the way the proposed law would go, the letters would go out explaining the cut, and it's going to come as a tremendous shock to many people.

So from that, I guess the other thing is I'm pleased to see Senator Pressler willing to look at this, because it's taken years for some of these programs to pass. If it's good enough to be enacted and changed 3 months from now, it's good enough to be looked at and considered.

I know with statistics, cold statistics can be very misleading. In 1972, the Social Security Administration was asked to take over and administer SSI, the supplemental security income program. The estimates for South Dakota said there should be about 400,000 people on SSI in 1974. We have never exceeded 9,000 in South Dakota. The figures were obtained from raw statistical data obtained from the Census Department. When you get into applying one type of criteria to another group, it's like mixing apples and oranges. It's very interesting and worthwhile to see the concern by Larry Pressler to look at some of these issues. I think it does have a tremendous effect.

Social security is only a supplement to reduced earnings because of later life, death, or disability. A great number of people look to social security as everything. But in order for social security to take the role that it is supposed to take, which is to be a supplemental benefit, we've got to get Americans to save, so that social security is used only as a base or floor on which to build a total retirement, disability, or death situations. I don't know the answer to that. I wish somebody could provide Larry and the American public with that answer.

Besides the tremendous lack of knowledge of social security, there is the fear by many of social security's continuance.

I lump these concerns into three groups. There's the group that is 70 and older, a high percentage of these people live basically on social security. A lot of them are not working. They have a tremendous amount of time on their hands since they are not working in the labor market. They worry from day to day. I see that all the time. I see that on their faces and in their questions. "I got my social security today. Will it be here a year from now?" Tremendous fear exists out there. The fear that will there be any social security? I never thought I'd ever see that day in America where the majority of people would say that, but I've seen it and very realistically.

The second group I looked at is 4 or 5 years away from receiving social security. They are saying can I or should I? Will I have to continue working? That's a very realistic question, and I wish more people would be realistically looking at it.

I lump the third category into the younger set. So many of them saying, "I doubt if it will be around." From that standpoint, those three basic fears of social security, I think it's so important a program as big as it is, in excess or $150 billion in expenditure a year, a tremendous cost, with a tremendous outlay—that Americans should understand more about social security, but how we get across that understanding, I'm not sure how we do it, because I have heard many people

say that I've been promised that social security will provide for me, and they have, in turn, interpreted that it should provide my all in my retirement years. Social security has never been established that way. So apparently we are not getting the word across. It's been assumed by the public that we will fill that void entirely. I think if anything could be done, it will have to be a commitment by social security and the American public in a joint effort to try to understand more about social security.

There are some very good proposals on the drawing board for social security. Some are really making people very nervous and upset. I think part of it comes from the fact that many people don't understand the proposals, and logic hasn't always been used in explaining things.

For example, let me give you one that really smacked hard in America, and if you stop and look at it, it's a good proposal. Increasing the reduction rate for people drawing at age 62. At present, there is a 20-percent reduction for someone taking a benefit at 62; the proposal would increase this to 55 percent at age 62. A tremendous cut, but it is a very good proposal, but it is not necessarily a very good proposal for next January, because a person that's 61 today has not had a chance to prepare for that change.

For example, in social security, we started paying reduced benefits at age 62 in 1956. The life expectancy in 1956 was about 69 years old. Today, for a person turning 62 it's well up there, near 89. We have not changed that aspect in 25 years. People are living considerably longer. It's a very good proposal, but probably should be enacted down the road. I think that's one of the key solutions to social security. Social security is earmarked to lose student benefits, and Larry mentioned it's a good proposal, as long as there are other avenues to pick up student loans for students that need benefits.

In summary, I know most of you have a tremendous concern. We have seen unprecedented phone calls, interest, inquiries on social security. I hear it everywhere I go. I'm sure many of you are here today because of social security. I sincerely appreciate Larry's interest in social security and I'm sure he'll represent you well.

Thank you.

Senator PRESSLER. Thank you very much, John. It is true that there are a lot of misunderstandings, but we are going to keep the social security program solvent.

Ruth Williams, our next witness, was in my Washington office as a senior citizen adviser a few years ago.

STATEMENT OF RUTH WILLIAMS, CHESTER, S. DAK.

Ms. WILLIAMS. Senator Pressler, fellow senior citizens, friends, I appreciate this opportunity to talk to you and I appreciate Senator Pressler asking me to come. Most of all, right now I appreciate Mr. Peterson giving you such an overall view of this, because I'm like the rest of you out here, I'm wondering about it, too. Senator Pressler's office sent me an awful lot of material, and I tried to go through it; but I still don't have all the answers, anymore than you do.

There's one thing I do have, and I hope that you will share it with me. That is faith in the justice of our governmental system, that

they will not leave us in the lurch, that something is going to be worked out. I don't want this to appear as rebuttal to Mr. Peterson, but I feel I must say that one of the reasons people say now, you promised us that social security would see us through our declining years, is that a few years ago it would do that. You could pretty well live on your social security. We got accustomed to that. All of a sudden inflation and all the rest of these things came along, and it will no longer take care of our problems. So we say, well, we are not getting what you promised us.

I think one of the answers to that is to make it possible for the elderly to work longer. Again, I say I don't have the answers to it, but I do know a lot of people, including myself, are not ready to sit down at 60 or 62 and say I'll just sit here and wait out the rest of my life and draw my social security check. I'd rather be out there doing something.

That's why these programs that they have talked about this morning are so dear to my heart. The senior companion that can help the elderly from having to go into a nursing home and also help the senior person, the volunteer, to feel as though she's doing something worthwhile, and if necessary, she's earning that little extra money to make her able to live on her income.

The volunteer grandparents last year in Pierre tried to get a program through for the severely mentally retarded or handicapped in Custer, but there was not money enough in our State budget that they felt they could do it, but I really feel that maybe some of the tragedy that we read about out there could have been alleviated or could have been taken care of had there been someone to fill in for those overworked people caring for those cases out there. I think these programs are so very necessary, not only to help to keep the elderly in their own homes, but to help the people who can do these services to have some meaning in their lives.

I'm concerned about the minimum benefit. It seems to me I hear all these different things, like maybe you could work at a job that pays a good pension until you retire. Then you could go out and work a short time and draw the minimum. Now, maybe I'm wrong about that. I hope John will have a chance to straighten out my thinking in this. But as in so many cases with social security, I think there are abuses that can be taken out of the system so that what it was intended for, something to help out the elderly in the later life.

When I was Senator Pressler's intern in Washington, one of the meetings we attended that meant the most to me was when the head of the social security at that time, and I can't say what his name was, spoke to us. We had a chance to talk, we had a microphone out in the crowd, and there were 170 of us. You could queue up and wait your turn and come to this microphone and ask your questions. That was one of the things that they were really concerned about was, how did it happen that all these extra things that really weren't intended for the elderly got put into social security? You know, he had a very good answer for it. He said the people that you elected and sent to Washington are the ones that put it in there, and that's the only way you're going to get it out. You know, folks, I think this is the year we might get something done about it.

I am concerned about the displaced homemaker, if they do raise the age of retirement, there are women farm wives, in particular, who

have no skills, and they look forward to the security of their social security that they can draw early. To my notion, that could be quite a devastating thing, if that is taken away from them. On the other hand, if there are programs made available for these women to work and to earn money, that might be a better thing than to keep the lower age of retirement.

I am concerned about double-dippers. It seems to me if a man or a woman has a good pension that he can live on, it's scarcely fair for him to use the social security system to augment that. Maybe I'm wrong, but this is what I'm thinking about. Those are the things that I would like to have looked into.

Another thing, I think, that most pensions are taxed. Social security, the smaller amounts would not be taxed; but if someone has a good income and they also have the maximum payment of social security, why shouldn't they pay a tax on that? I know you'll answer this is a Federal program and you don't tax a Federal program, but it seems to me that is one of the unfair aspects of it.

The young people going to college, I would hate to see the children of deceased or disabled workers cheated out of an opportunity to go to college; but I think there are other avenues through which this could be done. This is one of the things that is not part of the elderly program.

Women working as partners in small businesses, or especially here in South Dakota, on farms, should draw the same social security that the husband does. I really feel that this is unfair. It's discriminatory to say that because they work in the house, and many of them work beyond the house on farms these days, that they aren't entitled to the same social security that their husbands are.

I think elderly should be able to continue to work, drawing their social security at whatever age they come up with, but they should not be denied the opportunity to enrich their lives and to make their income better by continuing to work. Maybe there does have to be some kind of limitation on earnings, but it shouldn't be quite as drastic as it has been.

I tried to make some notes, and now I can't find them. I just have to say a little bit about medicare. I really feel that one of the things that is part of social security in my notion is medicare. One of the things that makes it so hard is that if you have a supplemental insurance policy, you're probably paying more for it than you are for your medicare. The medicare has to pay their share of it first, the 80 percent, before it can go to the supplemental insurance. This doesn't seem quite fair to me; but the thing I heard is a little scary, too, that if they make the supplemental insurance the carrier of first importance, maybe insurance rates are going to get clear out of line, too. These are all problems that have to be talked about and thought about, and that's what we're here for today is to bring these things to the attention of the committee so that they can consider them.

For homemaker programs, I don't know, do I get to say a little?

Senator PRESSLER. Go ahead.

Ms. WILLIAMS. For home health care programs, one of the sorriest things is the poverty guideline or income orientation. There are needs out there so great that are not attached to the poverty guideline; and I just feel very strongly about that, that we first consider the whole person, not just how much his income is.

I'll think of a lot of things as I sit down again, but right now I think that's what I wanted to say to the Senator.

I thank you.

Senator PRESSLER. Ruth, I thank you very much. I think a couple things you said are very important. One is the issue of women's rights. In the new estate tax bill that we have in Congress, we are correcting some of the inequities that recognize the contribution that a woman makes to the creation of an estate, even if she hasn't earned a paycheck in terms of the taxing system.

Also, let me say that I have long felt that we should lift the earnings limitation on social security recipients. A person can receive $1 million a year in interest income, or dividend income, or some other type of unearned income, and it wouldn't affect their social security, but if they worked, they lose that portion of it. This has been something that needs to be changed.

John, do you have any figures on how many South Dakotans receive the social security minimum benefit?

Mr. PETERSON. The only figures I've seen haven't been broken down by States. One thing, they have to go back and figure out from the individual records how many are in the various States. For example, they are estimating 2 million people will be affected by the payment. That's 1 out of 18 in America. It's anticipated the rural States will probably be more affected with this change in benefit. There were so many people in these States that did not work very much and only earned the minimum amount of coverage because the wages were so low here. They were not as high as in some of the cities.

[Subsequent to the hearing, Senator Pressler submitted questions to Mr. Peterson. Those questions and responses follow:]

Question 1. What major concerns have been expressed to you by social security beneficiaries?

Response. We have received numerous questions concerning pending proposals affecting social security. The following three concerns make up the majority of the inquiries:

(1) Financial status of social security.—In the last 6 to 8 months, there has been unprecedented news coverage on the anticipated future financial status of social security. Most of this news blitz has provided very little in background information about the situation other than to give them a definite feeling that social security will be broke and very soon. From this, the public then goes on to make their own assumption that there will not be any future benefits for them. We have received many very concerned calls from many beneficiaries wondering if this can and will happen. In summary, it is a matter of unmeasurable impact.

(2) Raising the retirement age.—Many people have been concerned about the potential raising of the retirement age from age 62 to 65. Those especially concerned are those in the age category of 60 or 61. These people are in a quandary about what they can or should do if the age is raised for them to receive social security benefits.

(3) Reduction of benefit amount.—Presently the reduction rate for someone taking their benefit at age 62 is 20 percent. The proposal to increase this reduction factor to 45 percent at 62 has caused many to wonder what it will do to their pending retirement plans.

Question 2. Have you received a large number of inquiries from people receiving the minimum benefit?

Response. Yes, we have received numerous calls. However, the news media has given the public the impression that the only minimum benefit amount that will be affected is the $122 benefit amount. When in effect many people receiving up to $170.30 will be affected by the minimum change. We're sure we will see considerable more inquiries once the actual reduction letters go out in December to the 1.8 million people that will receive reduced monthly benefits.

Question 3. Based on your evaluation of the inquiries, do most of these people receiving the minimum benefit qualify for SSI?

Response. Few if any at all would qualify for SSI.

Senator PRESSLER. The social security system is a very complex program and I realize that some aspects vary according to individual States. For example, in South Dakota, 69.2 percent of the people retire early, taking reduced benefits. I believe the reasons for this decision should be studied as we consider the possibility of eventually altering the retirement age. Also I would like to have your comments on recommendations made by the National Commission on Social Security and the President's Commission of Pension Policy to construct a special Consumer Price Index for the elderly. The Consumer Price Index has been criticized for not being an accurate measure to inflation for retirees. Do you feel this would be beneficial?

Ms. WILLIAMS. One of the things that I have heard is that housing should not be included in the CPI since elderly are not at this time, many of them, buying homes as the younger ones are. The cost of living is very important to this increase for each year is very important for our elderly to keep up. That would be the only suggestion I might have on that line.

[Subsequent to the hearing, Senator Pressler submitted the following question to Ms. Williams:]

Question. Do you find that the elderly women receiving the minimum benefit who have contacted you are receiving support from any other government programs?

Response. In this area, I do not find any elderly women receiving the minimum benefit. They may not have large enough social security payments to do without supplemental security income, but they aren't receiving the minimum benefit.

Senator PRESSLER. In conclusion, I wish to thank all the panelists for coming to offer their expertise and experience with elderly programs. As a member of the Senate Aging Committee, I intend to use this information as well as the suggestions and input I receive from all of you to formulate legislation which is more responsive to needs of rural elderly. In Washington, we often forget that these programs are administered by people here on the State and local level, and we need to alleviate any burdening regulations which detract from the effectiveness of the service to the elderly people.

Thank you all for coming.

[Whereupon, at 12 noon, the hearing was adjourned.]

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